

**AMENDMENT NO. 1
TO THE
2006 RESTATEMENT OF THE
RULES AND REGULATIONS
OF PLAN 501-B-1
OF THE
UNITED FOOD AND COMMERCIAL WORKERS AND
EMPLOYERS ARIZONA HEALTH AND WELFARE TRUST**

1. Effective December 1, 2006, the prescription drug summary of Section 4A.01 is amended and restated to read as follows:

	NETWORK	NON-NETWORK
Prescription Drugs – Generic	100% less \$10 co-pay per prescription	50%
Brand Name (when no generic exists)	100% less \$20 co-pay per prescription	50%
Brand Name (when generic exists)	100% less \$35 co-pay per prescription	50%
Mail at Retail for 90-day supply	100% less 2 times the applicable co-pay noted above	Not Available

2. Effective December 1, 2006, ARTICLE 4, Section 4A.03(bb) is amended and restated to read as follows:

(bb) **Prescription Drugs.** Charges actually incurred for drugs and medicines which are:

- (1) Prescribed by a legally qualified Physician; and
- (2) Available only by prescription; and
- (2) Approved by the U.S. Food and Drug Administration; and
- (4) Identified by a prescription number; and
- (5) Dispensed by a licensed Pharmacist or Physician.

Optional Prescription Drug Plan Network:

Charges incurred for medically necessary drugs and medicines which are dispensed by a participating Pharmacy of the Prescription Drug Network which meet the requirements set forth in items (1) through (5) above will be paid directly to the participating Pharmacy for covered charges for generic prescription drugs and charges in excess of the co-payments specified in the Schedule of Benefits for each 34 day supply or, under "Mail at Retail", for each 90-day supply.

The deductible does not apply to this benefit.

The Trustees may implement in the Prescription Drug Network a "Step-Therapy" program under which certain drugs will be covered by the Plan only after less costly alternatives have been explored. In furtherance of such a program, the Plan may provide coverage of non-prescription medications that would otherwise not be covered by the Plan.

3. Effective January 1, 2007, ARTICLE 2, Section 2.12 is amended and restated to read as follows:

Section 2.12 Utilization Review – Disease Management. The Fund may provide utilization review services through a Fund Nurse who will provide patient health care information services to help Covered Persons decide on their best treatment plan.

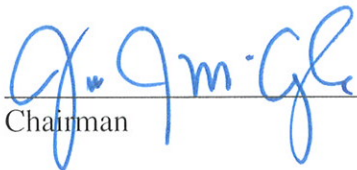
- (a) Non-Emergency Hospital Pre-Admission Review Services. If a Covered Person's physician recommends hospitalization for a Covered Person for non-emergency medical treatment or surgery, upon notification to the Fund Office before admission, the Fund Nurse may confirm whether hospitalization will provide the best possible treatment plan or whether an alternative, outpatient procedure may be more appropriate. The Fund Nurse or an advisory Physician will discuss the procedure with the Covered Person's doctor to help make this determination. If the Covered Person's doctor agrees with an alternative outpatient care recommendation, the Fund Nurse will assist the Covered Person in locating a suitable outpatient facility near the Covered Person's home. If the Covered Person's doctor does not agree with the review recommendations, the original plan may be followed.
- (b) Second Surgical Opinion Services. If surgery is recommended, the Covered Person may contact the Fund Nurse who will assist in determining if a second opinion is needed, or if outpatient surgery can provide a better treatment plan. The Fund will pay 100% of the charges for a second (or third, if necessary) surgical opinion, including diagnostic testing.

Compliance with the second surgical opinion services is not required for emergency surgery that must be performed in order to protect the Covered Person's health or life. The Fund Nurse may waive a second opinion, if appropriate.

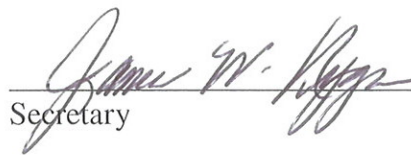
- (c) Hospital Continued Stay Review Services. When a Covered Person requires inpatient hospital care, and the Fund Office is notified, the Hospital Continued Stay Review Service can help assure that the Covered Person is discharged as early as possible without sacrificing quality care by monitoring the Covered Person's progress. When a Covered Person no longer needs acute care in a hospital, the Fund Nurse may recommend alternative care, such as outpatient care, home health care or the use of a skilled nursing facility.
- (d) Discharge Planning Service. During the course of Continued Stay Review, if it is determined that an alternative to an acute hospital stay would better meet the Covered Person's needs, the Fund Nurse may coordinate with the attending physician and appropriate facilities or services to encourage the best possible care for the Covered Person, with the most economical use of Plan benefits.

The Fund may also provide disease management services to help Covered Persons manage chronic illness.

The undersigned Chairman and Secretary of the UFCW and Employers Arizona Health and Welfare Trust do hereby certify that the foregoing Amendment to the Plan 501-B-1 Rules and Regulations was duly adopted by the Board of Trustees at a meeting duly called and held on the date noted below.


Chairman

1.18.07
Date


Secretary

1-18-07
Date